A CASE OF CÆCAL HERNIA.

SYMPTOMS OF STRANGULATION; HERNIOTOMY; WOUND OF THE BOWEL; SUTURE; RECOVERY.[1]

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CASES of cæcal hernia are sufficiently rare to be of interest, many surgeons having passed through a long course of hospital practice without ever having seen a case of caecal hernia. It is seen more commonly in children and is usually of congenital origin, being covered completely by peritoneum and lying in its own sac. In other cases, especially where the hernia is of the acquired form, it follows a pre-existing enterocele, the sac of which enlarging and growing downwards, tears away the peritoneum from the iliac fossa, and later, if the enlargement continues, partially deprives the cæcum itself of its peritoneal covering at the same time displacing and drawing down a portion of it. Such was the course of events, I imagine, in the case I am about to relate. These cases cannot be readily diagnosed before operation, and to the surgeon they offer great difficulties in operating for the radical cure. They are not easy of reduction and are often of large size.

Case. H. H., *aet.* 53, door-porter, was admitted into the wards of the Montreal General Hospital, on April 18, 1891, suffering from strangulated inguinal hernia.

History. Has been a soldier. For the last eleven years has had a right inguinal hernia, for which he has from time to time worn a truss. Occasionally the hernia comes down, but he has always been able to return it. Two years ago, whilst lifting

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a heavy weight, the hernia came down and was reduced with difficulty. A hard lump has remained in the inguinal canal ever since.

Three days ago the hernia came down and he could not return it. He went to his work as usual, but suffered considerable pain. He was constipated, but had no vomiting. The pain increased and the tumor became excessively tender. Constipation was marked and there was great nausea and loss of appetite. He had no severe vomiting. His condition not improving he was sent to the hospital for relief.

On entrance the following notes were made: "A strong, healthy-looking but spare man, *æt.* 53, but looks older. Has an expression of great suffering in his face, and complains of nausea and of great pain in right groin. On examination a sausage-shaped swelling is found at the site of the right inguinal canal, which is hard, tense, nodular, dull on percussion, and excessively tender. There is no impulse on coughing.

Below and continuous with this swelling and filling up the scrotum is a much softer tumor, which is neither tense nor tender. The man was immediately placed under ether and gentle taxis was employed, but without avail, so the operation of herniotomy was at once proceeded with.

Operation. The parts having been properly cleaned and shaven, an incision was made over the sausage-shaped swelling, and after cutting through the skin a dense, hard mass was met with, which appeared to be composed of fibrous tissue. On extending the incision below this mass the thin, bluish wall of a sac was discovered. This was incised and immediately about two ounces of a straw-colored fluid escaped. No intestine was found in this sac and it was supposed that the gut slipped back as the fluid was evacuated. The sac was now slit up to the upper end, through the thickened fibrous mass, and then an attempt was made to dissect it out. This was found to be a most difficult task, as it was very adherent. The floor of the sac was composed of an irregular cystic mass, with elevated ridges containing large blood-vessels. This mass, on close examination, proved to be omentum which had become incorporated with the posterior wall of the sac. Posteriorly the sac was so intimately blended with the spermatic cord that separation could not be

affected without destroying the vas deferens. So the cord was cut through and the testicle afterwards excised. The veins of the cord were enormously distended and the whole cord was in a state of cystic degeneration, which formed a mass below the hernial sac, causing the second swelling already alluded to. After a time I managed to separate the sac and the structures incorporated with it. The neck, which seemed to be thicker than usual, was freed beyond the internal ring, pulled down and then tied with strong silk. It was now turned up and scissors were used to cut it off. The first cut made from below, much to my surprise, opened into bowel. The ligature was immediately loosened and it was now found that the cut had been made into a collapsed portion of cæcum which was closely attached to the upper part of the posterior wall of the sac. On pulling this down further the appendix was seen. The cut in the bowel was about one and a half inches long and the part of cæcum opened was quite free from fæces. It, however, was well washed and then the cut was closed with a continuous suture of fine silk and a Lembert suture over this again. The omentum was separated from the sac, tied off and returned. The sac itself was ligatured below its attachment to the cæcum and the part in front cut away and then returned within the abdomen with the sutured cæcum. A radical cure was now performed by suturing the conjoined tendon to Poupart's ligament. The wound was sutured with silk-worm gut and a drain placed at the lower end.

The patient's condition was excellent at the end of this prolonged operation, and he had no vomiting afterwards. Next day his temperature and pulse were normal, there was some pain about the wound, but his condition was still excellent. On April 25th, six days after the operation, the wound was dressed, the tube removed and stitches taken out. There was union everywhere by first intention. He went on well, without a bad symptom, and was discharged from the hospital on the 16th of May with a small sinus persisting where the drainage-tube had been. He returned to the hospital on May 22d, saying he felt well and was attending to his work as usual. Had some pain and tenderness about centre of scar. June 5th, returned again, with a small suppurating point at centre of scar, through which

protruded a silk ligature. This proved to be one of the ligatures which united the conjoined tendon to Poupart's ligament. The sinus now quickly healed and the patient has felt well ever since, attending to his duties and suffering no pain. He has never worn a truss. In this case there was no doubt a double hernia, viz., one of the cæcum and one of the small intestines in front of the cæcum. The hernial sac, which contained the small intestines and omentum, had for its posterior wall the layer of peritoneum covering the cæcum, and as it descended it pulled the cæcum down with it. From prolonged use of a truss and inflammatory attacks which had occasionally occurred the sac was thickened and the omentum so fused with it that it really had become part of the sac. Closely incorporated with the posterior wall of the sac was the lower end of the cæcum, which was only covered in front by peritoneum, and as it was empty and the same color as the sac, from having been herniated, probably for some years, it was not recognized or even suspected, until, when cutting off the sac, it was opened. As soon as this occurred the cut bowel was pulled down and then it was recognized as the cæcum, and the character of the hernia was at once apparent. The cut in the bowel was immediately sutured and no harm resulted. The removal of the right testicle was a necessary proceeding, for the cord and sac were so blended that a separation without injury was not possible. In one way the sacrifice of the testicle was a great gain, in that it helped to make the radical cure more certain, an additional plug in the canal being provided by the stump of the cord.